PLEASE DO NOT STAPLE						Screening							
IN THIS AREA						Indicator							
					°Immuniza			4 50	DM.				
PICA 1. MEDICARE MED	ICAID CH	AMPUS	CHAMPVA	GROUP	FECA OTHER	SURANCE C				(FOR P	PICA ROGRAM IN ITE		
(Medicare #) X (Med		onsar's SSN)		#) HEALTH PLAN (SSN or ID)	BLK LUNG (SSN) (ID)	900000000M							
2. PATIENT'S NAME (Last N	lame, First Name,	Middle Initia	il)	3 PATIENT'S BIRTH DATE 09 06 2000	SEX M X F	4. INSURED'S NAME	(Last Na	me, Fin	st Name.	. Middle	Initial)		
Burny, Buggs 5. PATIENT'S ADDRESS (N				6. PATIENT RELATIONSHIP		7. INSURED'S ADDRE	ESS (No	., Street)				
22 Sylvester					nild Other								
CITY			STATE NC	8. PATIENT STATUS Single Married	Other	CITY					STATE		
Raleigh ZIP CODE	TELEPHON	IE (Include A		1	:	ZIP CODE		TEL	EPHON	IE (INCL	UDE AREA COD		
27600	(919)			Employed Full-Time Student 10. IS PATIENT'S CONDITIE	Student	11. INSURED'S POLIC	CV GBC	HIP OR	() UMBER			
9. OTHER INSURED'S NAM	it (Last Name, Fir	st name, Mic	udie illilai)	10. IS PATIENT S CONDITIO	SITTLE TO	III. INGONED STOCK	or uno	01 011	COATE	ONIDE	•		
a. OTHER INSURED'S POL	ICY OR GROUP N	IUMBER		a. EMPLOYMENT? (CURRE	NO	a. INSURED'S DATE (м		SEX F		
b. OTHER INSURED'S DAT MM DD YY	E OF BIRTH	SEX	F	b. AUTO ACCIDENT? YES	PLACE (State)	b. EMPLOYER'S NAM	E OR S	CHOOL	NAME				
c. EMPLOYER'S NAME OR				c. OTHER ACCIDENT?		c. INSURANCE PLAN	NAME	OR PRO	GRAM N	NAME			
				YES 10d. RESERVED FOR LOCA	d IS THERE ANOTHE	D NE V	TH DEA	EFIT D	AN?				
d. INSURANCE PLAN NAME OR PROGRAM NAME				IOI. RESERVED FOR LOCA	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, return to and complete item 9 a-d								
12 PATIENT'S OR AUTHOR	RIZED PERSON'S	SIGNATUR	IF I authorize the	3 & SIGNING THIS FORM. release of any medical or other	information necessary	13. INSURED'S OR AU payment of medica	I benefit	ZED PE	RSON'S	SIGNA	TURE I authorize		
to process this claim. I at below.	so request paymen	t of governme	ent benefits either	r to myself or to the party who ac	cepts assignment	services described	below						
SIGNED				DATE		SIGNED							
14. DATE OF CURRENT:	14. DATE OF CURRENT: ILLNESS (First symptom) OR MM DD YY INJURY (Accident) OR				IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YX			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY TO					
17. NAME OF REFERRING	PREGNANCY(I												
	PHYSICIAN OR O	THER SOU	RCE 17a	. I.D. NUMBER OF REFERRIN		18. HOSPITALIZATION	N DATE	S RELAT	ED TO	CURRE	NT SERVICES		
		THER SOU	RCE 17a			18. HOSPITALIZATION MM DD FROM	N DATE	S RELAT	TED TO	CURRE	NT SERVICES DD YY		
19. RESERVED FOR LOCA		THER SOU	RCE 17a			18. HOSPITALIZATION FROM DD FROM 20. OUTSIDE LAB?	N DATE:	S RELAT	TED TO	CURRE	NT SERVICES DD YY		
	L USE				G PHYSICIAN	18. HOSPITALIZATION DD FROM 20. OUTSIDE LAB?	N DATE:	S RELAT	TED TO	CURRE MM RGES	NT SERVICES DD YY		
	L USE		RELATE ITEMS	. ł.d. Number of Referrin	G PHYSICIAN	18. HOSPITALIZATION MM DD FROM 20. OUTSIDE LAB? YES 22. MEDICAID RESUR	NO SMISSIC	N ORIG	TO TO \$ CHA GINAL R	CURRE MM RGES	NT SERVICES DD YY		
21. DIAGNOSIS ÖR NATUR	L USE	R INJURY. (F	RELATE ITEMS	1.D. NUMBER OF REFERRIN 11.2.3 OR 4 TO ITEM 24E BY LI 3	G PHYSICIAN	18. HOSPITALIZATION FROM DD FROM DD 20. OUTSIDE LAB? VES 22. MEDICAID RESUE CODE 23. PRIOR AUTHORIZ	NO YY	N ORIG	TO TO \$ CHA GINAL R	RGES EF. NO	NT SERVICES DD YY		
21. DIAGNOSIS OR NATUR 1. LV202 2. L3829 24. A	L USE IE OF ILLNESS OF	B (Place Ty	RELATE ITEMS	1.2.3 OR 4 TO ITEM 24E BY LI 3. L. D. D. D. D. S. SERVICES, OR SUPPLIE	G PHYSICIAN NE) E S DIAGNOSIS	18. HOSPITALIZATIO FROM DD DD FROM DD DD 20. OUTSIDE LAB? VES DD 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ	NO PATENDA PAT	ORIO NUMBEI	TO TO S CHA	RGES EF. NO	NT SERVICES DD YY		
21. DIAGNOSIS OR NATUR 1. LV202 2. L3829	L USE IE OF ILLNESS OF	R INJURY. (F	C C PROCEDUIO CENTRO CE	1.2,3 OR 4 TO ITEM 24E BY LI 1.2,3 OR 4 TO ITEM 24E BY LI 3. L D 1 D 1 D 1 D 1 D D S.S MODIFIER	G PHYSICIAN NE)	18. HOSPITALIZATIO FROM DD DD FROM DD DD 20. OUTSIDE LAB? 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ F \$ CHARGES	NO BMISSIC PATION OR UNITS	ORIO NUMBEI	TO TO S CHA	RGES EF. NO	NT SERVICES DD YY		
21. DIAGNOSIS OR NATUR 1. L_V20 2 2. L_382 9 24. A Prom DATE(S) OF SEI	L USE E OF ILLNESS OF RIVICE TO A DD YY	B (Place Ty of Service Ser	C PROCEDUIO (Explaryors CPT/HCP) 99392	1.2.3 OR 4 TO ITEM 24E BY LI 1.2.3 OR 4 TO ITEM 24E BY LI 3. L	G PHYSICIAN NE) E S DIAGNOSIS	18. HOSPITALIZATION FROM MM DD 20. OUTSIDE LAB? 22. MEDICAID RESUB 23. PRIOR AUTHORIZ F \$ CHARGES 80. 33	NO BMISSIC DAYS OR UNITS	ORIC NUMBE H EPSDT Family	TO TO S CHA	RGES EF. NO	NT SERVICES DD YY		
21. DIAGNOSIS OR NATUR 1. L. V202 2. L. 3829 24. A DATE(S) OF SEI FROM MM DD YY MM 11. 22. 02. 11	L USE E OF ILLNESS OF EVICE TO A DD YY	B (Place Ty of Service Service	C C PROCEDUIO CENTRO CE	1.2.3 OR 4 TO ITEM 24E BY LI 1.2.3 OR 4 TO ITEM 24E BY LI 3. L	G PHYSICIAN NE) E S DIAGNOSIS	18. HOSPITALIZATIO FROM DD DD FROM DD DD 20. OUTSIDE LAB? 22. MEDICAID RESUB CODE 23. PRIOR AUTHORIZ F \$ CHARGES	NO BMISSIC PATION OR UNITS	ORIO NUMBEI	TO TO S CHA	RGES EF. NO	NT SERVICES DD YY		
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21. DIAGNOSIS OR NATUR 1. L V202 2	A DD YY 22 02 22 02 22 02 22 02 22 02 22 02	B (C) Place Ty of C Service Servital Service Servital Ser	PRELATE ITEMS Graph PROCEDUIG (Explain) 99392 90471 90642 90665	1.2.3 OR 4 TO ITEM 24E BY LI 3. L DESCRIPTION OF SUPPLIE BY LI BY LI	B E S DIAGNOSIS CODE	18. HOSPITALIZATIO FROM MM DO FROM MM DO 20. OUTSIDE LAB? 22. MEDICAID RESUB 23. PRIOR AUTHORIZ 23. PRIOR AUTHORIZ 80. 33 13. 71 13. 71 0. 00 0. 00 0. 00	NO NO TENT OF THE PROPERTY OF	N ORICE NUMBEI H EPSOT Family Plan R	S CHA	RGES EF. NO COB	K RESERVED FC LOCAL USE		
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